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IX. Review Procedure

10/93 A. Inpatient Rate Reviews. Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of the rate for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of their rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

==07/95 B. Hospitals reimbursed in accordance with Chapter VIII., and Chapters IV. and VII. with respect to per diem add-ons for capital may request that an adjustment be made to their base year costs to reflect significant changes in costs which have been mandated in order to meet State, federal or local health and safety standards, and which have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be received, in writing, by the Department within 30 days after the date of the Department's notice to the hospital of their rates. Such request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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==07/95 C. DSH Determination Reviews. Hospitals shall be notified of their qualification for DSH payment adjustments and shall have an opportunity to request a review of the DSH add-on for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of its DSH qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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10/92 1. DSH determination reviews shall be limited to the following:

10/93 a. DSH Determination Criteria. The criteria for DSH determination shall be in accordance with Section C. of Chapter VI. Review shall be limited to verification that the Department utilized criteria in accordance with federal and State regulations.

10/93 b. Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section C.8.e. of Chapter VI. Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

c. Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act and Sections C.1.b. and C.4. of Chapter VI. of this State Plan. Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.

07/95 d. Federally Designated Health Professional Shortage Areas (HPSA's). Illinois hospitals located in federally designated HPSA's shall be identified in accordance with 42 CFR 5, 1989, and Section C.1.c. of Chapter VI. of this State Plan based upon the methodologies utilized by, and the most current information available to the Department from the Department of Health and Human Services as of June 30, 1992. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSA's only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of June 30, 1992.

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10/93 e. Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 (89 Ill. Admin. Code, Section 148.120(a)(3) and 77 Ill. Admin. Code, Section 1100) and Section C.1.c. of Chapter VI. of this State Plan based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.

10/93 f. Medicaid Obstetrical Inpatient Utilization Rates. Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Sections C.1.d., C.8.d., C.8.f., and C.8.g. of Chapter VI. Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.

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==07/95 D. Outlier Adjustment Reviews. The Department shall make outlier adjustments to payment amounts in accordance with Chapter V. or Section F. of Chapter VIII., whichever is applicable. Hospitals shall be notified of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation only. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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==07/95 E. Cost Report Reviews. Cost reports are required from: 1) all enrolled hospitals within the State of Illinois; 2) all out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and 3) all hospitals not located in Illinois that elect to be reimbursed under the DRG PPS. The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days of the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report which may contain adjustments and revisions which may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis which support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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==07/95 F. Trauma Center Adjustment Reviews.

==07/95 1. The Department shall make trauma care adjustments in accordance with Section E. of Chapter VI. Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation.

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10/93 2. Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.

10/93 3. Appeals under this Section must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for reiew.

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==07/95 G. Medicaid High Volume Adjustment Reviews. The Department shall make Medicaid high volume adjustments in accordance with Section F. of Chapter VI. Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

==07/95 H. Sole Community Hospital Designation Reviews. The Department shall make sole community hospital designations in accordance with Section B. of Chapter VI. Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

==07/95 I. Geographic Designation Reviews

==07/95 1. The Department shall make rural hospital designations in accordance with Section B.3. of Chapter XVI. Hospitals have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be made in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

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==07/95

2.The Department shall make urban hospital designations in accordance with Section B.4. of Chapter XVI. Hospitals have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be made in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

==07/97

~~d. Appeals~~

~~--07/96~~

~~1.Right to appeal. Any hospital seeking to appeal its prospective payment rate for operating costs related to inpatient care or other allowable costs must submit a written request to the Department on or before July 31, 1995. The written request must contain the information as specified in Section 3 below. The Department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the Department, whichever is later. The hospital shall bear the burden of proof throughout the appeal process.~~

~~04/94~~

~~2.Non-appealable issue. The October 1, 1993, rates and reimbursement systems used to calculate the rates are not appealable.~~

~~04/94~~

~~3.Appeal documentation.~~

~~04/94~~

~~a.The hospital must submit an explanation of the circumstances creating the need for the appeal, including a detail of the hospital services that will be significantly curtailed if the hospital is not granted financial relief. The explanation must include a statement of attestation signed by the hospital's chief executive officer, chief financial officer, treasurer or its properly authorized agent. The signature verifies by written declaration, and under penalties of perjury, that the signing officer has personally examined the documentation and that the information is true, correct, and complete.~~

TN # 97-11 APPROVAL DATE MAR 19 1998 EFFECTIVE DATE 07-1-97

SUPERSEDES

TN # 96-13